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ABSTRACT

Client orientation should be an individualized, ongoing process which provides not only information about rehabilitation programs and services but also encourages and ensures the individual's involvement and participation in his or her own program. Ten guidelines to be considered in developing client orientation programs are (1) providing referring agencies with adequate, correct information on the facility's programs and services, (2) encouraging intake visits by clients prior to beginning the program, (3) ensuring that initial interviews establish rapport between client and program coordinator and exchange information to serve as a basis for joint planning, (4) providing the client with a handbook describing facility policies and procedures, (5) arranging "orientation" groups, (6) using audiovisual materials during orientation, (7) involving the client in decision making, (8) considering client advocacy, (9) involving significant others, and (10) conducting exit interviews. (YLB)

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CLIENT ORIENTATION: A KEY TO SUCCESSFUL INVOLVEMENT IN REHABILITATION FACILITY SERVICES

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Introduction

Client orientation is often thought of as being a "one-shot" activity which usually takes place at or near the beginning of an individual's rehabilitation program. Thus, in a single session or day, the client is informed of everything he or she needs to know in order to get along successfully in the rehabilitation facility. Once this task is dispensed with, the facility staff can get down to the more important business of "putting" the client through the program.

Hopefully this rather narrow view of client orientation is beginning to disappear, and will soon be replaced by one which recognizes the true importance of this process. Since rehabilitation owes its existence as a profession to the disabled or disadvantaged individual, it would seem logical that the importance of the individual's role in the rehabilitation process would be recognized as being paramount to that process. However, like most social services, rehabilitation has its roots in a medical-psychological model; a model where traditionally the all-knowing professional administers his or her expertise to meet the needs of the uninformed lay person, patient, or client. These needs themselves in many cases were determined solely by the professional without seeking client input. Previously to question this model was in many instances comparable to criticizing Mom, apple pie, and love of country. Clients who happened to do so were often referred to as being "uncooperative," "troublemakers," "unmotivated," or some other label appropriate to the level of the indiscretion. Of course, when these same clients turned out to be unsuccessful in a program, the staff could readily come up with an explanation simply by referring back to the label. One factor which undoubtedly has contributed to this situation can be traced to the process emphasis on the 26 closure as a measure of rehabilitation success (Cooper and Parker, 1975). By using a quantitative measure of success rather than a qualitative one, the client has been placed in an unfortunate position. This is undoubtedly an oversimplification of a rather complex issue. However, the point can be made that the importance of the client's role in the rehabilitation process has not always been recognized by rehabilitation professionals, with the possible exception of a few individuals (Genskow, 1970; Fischer, 1970; Nadolsky, 1973; Johnson, 1973). The end result has been that professionals take responsibility for "successful" cases, but when a program is not a success, it usually is considered to be the client's fault. This is a curious "double standard" which on one hand recognizes the client's responsibility, but which on the other hand doesn't. Paraphrasing Johnson (1973), rehabilitation professionals have allowed a caste system to develop in which clients are viewed as second-class citizens; in fact, they may even be relegated to the position of third-class citizens with the second-class consisting of family and friends.

As the popular folk ballad of the 60's states, "but the times they are a changing." A major change which appears to be impacting on every segment of society is the emergence of the consumer movement. Consumerism is also making itself felt in rehabilitation as well, and will certainly be a major factor in determining the future direction of the rehabilitation service delivery system. According to Miller (1971), rehabilitation agencies must form a partnership with the community, including consumer groups, if they are to survive. A more immediate consequence is that the individual will have an expanded role in determining the scope and direction of his or her own rehabilitation program. This is

already evident in the Rehabilitation Act of 1973, which provides for joint development of the rehabilitation plan by the counselor and client. Although this has legal ramifications primarily for state VR agencies, it also has important implications for rehabilitation facilities and workshops in terms of providing client-centered services (Dunn, 1973).

The double standard which was referred to earlier can be reduced or eliminated by recognition of the client's proper role in the rehabilitation process. Thus, the client is not only the focus of services, but also a partner in planning and carrying out these services. The client and the professional share a joint responsibility for failure as well as for success. In rehabilitation facility programs, the client must be informed in order to fully participate as a member of the partnership. When considered from this viewpoint, the process of client orientation takes on a much more important perspective.

Guidelines for Developing Client Orientation Programs

A client orientation program should consist of more than simply providing the client with information about an agency's service structure. Information about programs and services is certainly important, but it is just one part of a complete client-centered orientation program. The primary purpose of an orientation program should be to encourage and insure the individual's involvement and participation in his or her own program. This is true regardless of whether the program is vocational evaluation, work and personal adjustment, or vocational or skill training.

For many clients, orientation is an ongoing process which will continue throughout their program. However, each client's needs will differ, and therefore, the orientation should be flexible. In other words, each individual should not go through the same orientation program, but rather, like other services, the orientation should be designed to meet the level and needs of the individual. What follows are some considerations for establishing an effective client orientation program.

1. Begin with the Referring Agency

Since most clients come to facilities from an outside source, it is extremely important that referring agencies, and particularly individual representatives of those agencies, have a good understanding of the facility's program and services. As a result of being well-informed, referring counselors will be able to make meaningful referral decisions based on meeting identified client needs for services. In addition, they will also be able to share accurate information about a program with prospective clients. The use of audio-visual orientation materials, such as the MDC's "Client Orientation: Introducing You to Vocational Evaluation," can be very helpful in this process. Thus, the referring counselor and client can discuss the relative merits and appropriateness of a program in terms of meeting clients' needs. The MDC is developing materials (available summer 1977) on conducting initial diagnostic interviews which is designed to assist rehabilitation personnel in identifying specific client needs. Use of these procedures should lead to "good" referral decisions and individualized plans for services.

In their dealings with referring agencies, it is important that facilities never misrepresent their services. They should make sure that their facility can provide the services that they say it can. Those client services and programs that the facility does well should be emphasized. If a service which a client needs can't be provided, then a recommendation should be made that the individual consider another facility or service. Referring agencies in all likelihood will appreciate this kind of honesty. The goal is to receive referrals for clients who will be able to benefit from services. Hopefully, the referring counselor will involve the client in making the referral decision. This is the referring agency's responsibility, but one that the facility can contribute to and encourage.

2. Encourage an Intake Visit

Whenever possible, clients should be encouraged to visit the facility prior to beginning the program. In fact, this should be a requirement to which there are very few exceptions. Some persons might react by saying that this is often impossible when clients live considerable distances from the facility. It is in such cases that an intake visit may be most important. During the visit, potential problems which might interfere with the client's program can be identified. The responsibility for making the arrangements for the client's visit rests with the referring counselor. This responsibility should be spelled out in the facility's referral agreement or policy.

The client's visit provides both parties with the opportunity to determine if the program is "right" for the client. Does the client know the reason why he or she has been referred to the agency? The facility may not be what the individual had expected it to be. On the other hand, it might also be determined that the facility's services are not appropriate for a particular individual. In such cases, an effort should always be made to provide the client and the referring counselor with alternatives.

Assuming that the referral decision has been a "good" one, the intake visit can be helpful in alleviating any anxiety that the client may have about beginning a new program. It is important to allow sufficient time during the client's visit, and not simply rush the individual through on a quick tour of the facility. Assigning a staff member to serve as a referral and intake coordinator can help to ensure that the initial visit serves as an important part of the orientation process. The amount of time allowed for the visit will vary according to the needs of the individual. The client should be encouraged to observe, ask questions, possibly sit in on a group discussion, or try an evaluation or workshop task.

Whenever possible, it is important to emphasize the human aspects of the facility as opposed to structural or program elements. It is especially important to show and explain those programs and services in which the client has an interest or will be involved. The individual should understand how the program will relate to his or her own expressed needs. It may be helpful to introduce the client to those people whom he or she is likely to have contact with once their facility program begins. This could include persons ranging from the director of the facility to the janitor or cook. It may also be helpful to have the client meet and spend some time with individuals already participating in the program, possibly during a work or lunch break. However, it is important to be sensitive to the possibility of placing the client in a potentially threatening situation. For example, if the client appears reluctant to mix with other clients, it is probably best to avoid placing him or her into this situation. This could have the negative effect of eliminating the advantages gained from the intake visit, and could result in the client's losing interest in the facility's program altogether. This caution is not necessary in most situations, but staff members should be aware of the possibility that such things can occur.

The intake visit also provides an opportunity for completing certain clerical tasks which would otherwise have to be accomplished during the first few days of the client's program. This includes filling out application blanks, earnings or wage forms, release statements and other general clerical forms. By getting these routine matters out of the way, the client can get right into the program when he or she shows up on the first day.

Following the client's visit to the facility, both parties, client and facility staff, should have a better idea of whether or not a facility's services will meet the client's needs. The client should be encouraged to report back to the referring counselor

with his or her impressions of the facility. The referring counselor should then be contacted to determine the final referral decision. If the decision is positive, a starting date for the individual can then be established. In summary, an initial visit by the client to a facility should accelerate the client's adjustment once he or she begins the program.

3. Conducting the Initial Interview

In addition to the intake visit, the client's first interview when he or she actually begins the program is a very important part of the continuing orientation process. Because of the importance of the initial interview in identifying client needs for services, the MDC is developing materials for use in conducting initial diagnostic interviews. Whenever possible, it is recommended that the person who is responsible for coordinating the client's program also conduct the initial interview. The initial interview has essentially two functions. The first is to establish rapport between the client and his or her program coordinator; and the second is to exchange information which serves as a basis for joint planning between the client and the facility staff. If one of these functions is to take precedence, establishing rapport is most important because it can influence the success of the entire program. However, rapport can also be established within the activity of information exchange. The sensitive interviewer will be aware of whether or not this first function is being accomplished.

A starting point is provided by reviewing the intake visit and obtaining the individual's reactions to it. The client may have some questions and concerns which need immediate clarification. What are the client's expectations from services and how can the facility meet these? Review mutual responsibilities, both the staff's and the client's, and emphasize the importance of the individual's role in carrying out his or her own program. This provides a basis for joint development of the individualized service plan.

The initial interview generally should not last too long as most persons will be anxious to get started in the program. However, once again, this will depend on individual needs as some will need more information, support or reassurance initially than others. Generally, rather than conducting a lengthy session, it is perhaps best to hold a series of shorter interviews during the first few days for purposes of information exchange and joint plan development. This also provides a built-in mechanism for monitoring the individual's initial adjustment to the program. A more detailed discussion of the initial interview in the vocational evaluation process is found in an article by Lane (1972). The author indicates that the results of the evaluation should be directly shared with the client only when permission has been obtained from the referring counselor. This stipulation certainly places restrictions on the role of the evaluator, and represents a disservice to the client as well. However, the article was published when this view may have been more prevalent, particularly among state-agency counselors. There are still counselors who hold this viewpoint, although their numbers have probably diminished since the article was published. This transition has been a result of changes in federal legislation and subsequent changes in state VR agency policy. In spite of this statement, Lane does provide a valuable perspective on the initial interview as it relates specifically to vocational evaluation.

4. Provide a Client Handbook

It is important to provide the client with a handbook which describes the facility's policies and procedures. This gives the client and his or her parents something tangible to refer to when a staff member is not immediately available. Development of a good client handbook is easier said than done. Many facilities make the mistake of trying to include too much information in the handbook. A general rule to follow is, keep it basic.

In addition to information on facility rules, wage and salary policies, etc., the handbook should provide answers to common questions and concerns. This could be structured according to a "what do I do when" format. The general tone of the handbook should be positive.

The handbook should be addressed to the level of the client population. This can be a problem when the population is very diverse or when it is composed primarily of moderately and severely retarded individuals. However, this can still be accomplished without using patronizing language. Another goal to strive for is to try to make the handbook personal. As a result of paying attention to the tone and "person" in which the handbook is written, the handbook can read like it is addressed to each individual. It is also helpful to provide space in the handbook for the client to write in information and for making notes.

The handbook can be presented to the client during the intake visit or during the initial interview, whenever it seems most appropriate. However, when presented during the intake visit, the individual will have time to become familiar with its content prior to beginning the program. A brief explanation of the handbook can be provided at that time. However, this should be followed by a detailed review of the handbook. A good way of doing this is in small discussion groups with a number of new clients, rather than individually. Group discussion can be generated around a number of items in the handbook. This can make the handbook more meaningful than it might seem when reviewed with the client individually. Some persons may still have questions which they would like to discuss with their program coordinator. However, as a result of the group discussion, individual clients should be able to ask more specific questions which may be of concern to them.

A detailed discussion of the development and use of client handbooks is found in a publication by the University of West Virginia's Research and Training Center (Sankovsky, et al., 1975).

5. Arrange an "Orientation" Group

In addition to group discussion of the client handbook, it may be beneficial to form "orientation" groups for clients who begin their programs at relatively the same time. These groups are based on principles of group discussion, and are designed to assist individuals in the group in making an initial adjustment to the facility. Orientation groups could meet on a regularly scheduled basis until such time when group members decide that the meetings are no longer needed. It may be helpful to include clients in these discussions who have been in the facility program for longer periods of time. These "older" clients would in a sense serve as experts who could share their experience with the newer clients. The cohesiveness resulting from such groups can be very beneficial to new clients in establishing social relationships within the facility. As with any group situation, the person responsible for leading the group should be experienced in group dynamics, and sensitive to the feelings and needs of the individuals in the group.

6. Use Audio-visual Aids

In conducting an orientation program, there are a number of advantages which can be gained from the use of audio-visual orientation materials. Research has demonstrated that people retain more information when both seeing and hearing something, as compared to when just hearing or reading it alone. As in other areas of learning, this has important implications for the development of client orientation materials. Another important consideration is that audio-visuals can be used to standardize the orientation program. By putting the orientation into an audio-visual format, the facility staff can be assured that the information presented to each client remains constant. Even when a single staff person has the responsibility for conducting the orientation, this person may not always be consistent in delivering the necessary information, occasionally forget-

ting to include important facts or insights. By committing the orientation to an A-V format, certain human errors are avoided. As a result, a more consistent, effective basis for client orientation is established. As a word of caution, A-V orientation programs should be monitored in order to determine if the clients understand the information presented. More than one format may be needed according to differences in the client population. However, such needs can often be addressed by staff persons working with clients individually as opposed to developing totally new audio-visual programs.

A-V orientation programs can also be developed at several different levels of program emphasis. Developing a general program which depicts the agency's programs and services and its role in the rehabilitation delivery system is a good starting point. As offshoots to this general overview, individual A-V presentations which describe each of the service components in detail can be developed. The focus of all such orientation materials should be on client-centered concerns and issues, as opposed to the public relations emphasis of materials designed for educating the general community.

A 35mm slide/audio tape cassette format is perhaps the most practical audio-visual media for most facilities to consider, unless someone on the staff is trained and adept in another media, such as videotape. However, the slide/sound format offers a number of advantages. First of all, this approach to media development is relatively economical. In addition, many facilities already have the equipment on hand needed to produce and use slide/sound programs. Another important advantage of the slide/sound format is that the resulting materials can be easily updated or changed. This is accomplished by replacing a few slides and narrating a new cassette tape. The MDC slide/sound presentation, "Client Orientation: Introducing You to Vocational Evaluation," was developed to assist clients in learning about vocational evaluation so that they can derive maximum benefit from their own vocational evaluation programs. Facilities can use this presentation as a guide in developing audio-visual orientation materials about their own programs.

Such materials can also be made available to counselors from referring agencies. This can be helpful to them in developing a better understanding of the facility and in turn, may indirectly result in more appropriate referral decisions. A discussion of this approach to client orientation is found in a journal article by Esser and Scheinkman (1975).

7. Involve the Client in the Decision-making Process

It is important that the client have more than a "token" role in decision-making at the beginning of program planning. The Commission on Accreditation of Rehabilitation Facilities' standards (CARF, 1976) emphasize involvement of individuals and their families throughout rehabilitation service programming. The CARF standards indicate that "the individual's ability to learn about himself as a result of the information obtained and furnished" is a key factor in vocational evaluation services. The MDC materials on evaluation planning (available Summer 1977) represent an approach to client involvement in vocational evaluation planning which is consistent with the CARF standards.

A commitment should also be made to continue to share decision-making responsibility as the client progresses through the program. In referring to the vocational evaluation process, Nadolsky (1973) makes the following statement, "the client must learn to make meaningful decisions, to become responsible for the choices that he makes, and to act upon these choices in a manner that will enhance his own vocational development." In order to accomplish this, it is imperative that the client be provided with objective feedback about his or her performance on a systematic basis. The nature of this feedback will depend on the needs of the client as well as the activities in which the individual is involved. Each person should be provided with some feedback on a daily basis. Daily feedback can be most

readily provided by persons working closest with the client on a particular activity. Again, depending on what the client is doing, some feedback should be immediate to the task. Evaluation feedback should relate to the individual's expressed interests and demonstrated skills, and whenever possible, to jobs which exist in the community. Adjustment feedback should be provided in terms of those goals and objectives which are stated in the client's adjustment plan. Graphs, charts, production tallies and other tangible, visible indicators of performance and behavior can be very useful in providing this information. Feedback is a two-way process which implies that the client is presenting the staff with his or her reactions about what is happening. Staff members should be "tuned in" so that they can both solicit and respond to client feedback.

It may also be beneficial to conduct a feedback interview. This "feedback interview" provides a formal mechanism for reviewing the client's program. The responsibility for arranging the feedback interview rests with the client's program coordinator. All members of the rehabilitation team, including the client, parents or spouse, and referring counselor should attend. This "feedback interview" would both theoretically and practically take the place of the "client staffing." It also provides the client with the opportunity to give the staff his or her reactions to and insights about the program. Adjustments to the program could then be discussed and plans for making changes made. As a result of having this kind of input, the client is likely to feel that he has some degree of control over his own program. A research study by Tseng (1970) lends support to this practice in that it was found that clients who viewed themselves as having some control over their own programs tended to receive higher instructor's ratings on job proficiency and quality, and also indicated a higher degree of training satisfaction on self-ratings.

8. Consider Client Advocacy

A client advocate is a person who has the responsibility of making sure that the client understands what is happening during the program, and that the individual's needs are being met through services. A facility could establish an advocacy program by rotating the "client advocate" role among staff members. The referring counselor in many instances may assume the advocacy role. Undoubtedly, implementing such a system is not without problems. Client advocacy is a time-consuming responsibility in addition to a person's regular duties. In addition, personality conflicts between staff members could lead to numerous problems with the client ending up caught in the middle. For an advocacy program to be successful, the role of the advocate must be clearly defined. The person in this role is in a very delicate position. The advocate must be careful not to impinge upon the responsibilities of the client's program coordinator, except in instances where there appears to be a good reason for doing so. By rotating the advocacy responsibility among staff members, or by having a person from outside the agency in this position, many potential problems can be avoided. However, close communication and cooperation among staff members is required to make advocacy work. For advocacy to be successful, the facility staff must be committed to the concept of active participation by the client in determining the direction of his or her own program. In essence, an advocacy program serves as a mechanism which is designed to insure that this does happen.

9. Involve Significant Others

Very few individuals go through a facility program without having some continued contact with persons from their family and peer groups. Parents, spouses, and friends can all have a significant effect on an individual's adjustment to the facility. This influence can have both positive and negative consequences. Staff members should be conscious of these possible consequences and be prepared to assist the client in dealing with them. As a general rule, it is usually helpful to include parents and spouses in the initial orientation to the facility. The most appropriate time for this is during the intake visit.

By having a better understanding of a program and how it will benefit their child or spouse, it is likely that family members will be supportive of the client's involvement in that program. Beyond an initial orientation, the need for continued parental or spouse involvement is best handled on an individual basis. In some cases, continued involvement may be of critical importance to the success of the client's program, and in others, it may prove to be an obstacle to be confronted. For example, domineering parents in some instances may have to be kept at "arms length," so to speak. When problems do occur, the client should be consulted as to how he or she would like the situation handled. In any event, close cooperation between all involved persons is very important in order to prevent small problems from becoming even more serious.

Although the referring counselor's part in orienting the client to the facility has been discussed elsewhere, additional mention of this role is appropriate. The referring counselor's continued involvement is important to the delivery of effective services. The counselor wants to be aware of the client's adjustment to the facility and the degree to which the client is participating in the program. Since the referring counselor in most cases retains administrative responsibility for the client, it is important that the counselor be kept informed. One of the best ways of doing this is by telephone. It is a relatively simple matter to call the referring counselor periodically to report on the client's progress. Most referring counselors will appreciate this courtesy, and it can do much towards cementing a good working relationship between the facility and referring agency. These telephone calls should be documented in writing and entered into the case record. Of course, telephone calls do not take the place of written reports or case staffings in which the referring counselor is also involved. Involvement of the referring counselor is the responsibility of the individual client's program coordinator.

10. Conduct an Exit Interview

If client orientation is considered to be an ongoing process which continues throughout the facility program, then its natural conclusion occurs when the client is ready to leave the facility. The exit interview provides continuity for the client's program and helps prepare the individual for the transition which is about to take place. It should be attended by the members of the rehabilitation team including the client, the referring counselor, and as appropriate, members of the client's family and other service agencies. It should include a summary of the client's program and a discussion of specific recommendations and plans for additional services. It is also at this time that the responsibilities of all parties should be clearly spelled out, including who is to do what from this point on. This includes plans for follow-up or follow-along services.

The exit interview also provides the client with an excellent opportunity to present his or her impressions and reactions concerning the program to the facility staff. If the staff has done its job in involving the client throughout the program, there are likely to be few surprises. A structured feedback form may be helpful in soliciting program-specific information which can be shared with the staff. As a result, service components which may need improvement can be identified. Incorporating client feedback into the exit interview serves to emphasize once again the importance of the client's involvement to the rehabilitation process.

Summary

In many respects, the principles outlined in this manuscript represent a much broader view of client orientation than those which are reflected in actual practice in many facilities. Without thorough, ongoing orientation to the various components of a rehabilitation program, the client cannot be expected to participate fully in that program. To limit the role of the client, in many ways is to limit the process itself. Johnson (1973)

supports this in the following statement, "a system that enhances client involvement and expects a client to be a fully participating, responsible, and involved member of the rehabilitation team would seem to be one which will facilitate the client's total life adjustment."

It is obvious that all of the considerations presented here may not be practical or appropriate for each and every facility. However, by reviewing these principles, the facility can look at its own orientation program in order to determine if it can be improved. The delivery of effective, individualized rehabilitation services is a goal which is not likely to be accomplished without the client's full participation. In order to do this, the client must be provided with complete, objective information and feedback not only at the beginning of a program, but also continuing into and through the program itself. This requires a commitment from the facility administration and staff in order to make it happen. Once again, paraphrasing Nadolsky (1973), "In a rapidly changing society, vocational rehabilitation programs must emphasize the development of individual decision-making behavior. If decision-making and self-evaluation are not emphasized, many clients will require additional and continuing services as their jobs are terminated due to technological change. As a result, these individuals will remain dependent upon a well-intentioned, but obsolete rehabilitation process."

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